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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARY MONICA FEDULLO** 6162 Cottle Road, Apartment #B-7 San Jose, CA 95123 Registered Nurse License No. 325478, Respondent.	Case No. 2007-200 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about February 28, 1981, the Board of Registered Nursing ("Board") issued Registered Nurse License Number 325478 to Mary Monica Fedullo ("Respondent"). The license expired on March 31, 2005, and was renewed on inactive status. The inactive license will expire on March 31, 2007, unless renewed.

JURISDICTION

3. Section 2750 of the Business and Professions Code ("Code") provides:

"Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [Article 3 of the Nursing Practice Act (Bus. & Prof Code, § 2700 et seq.)]. As used in this article, "license" includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act], and the board shall have all the powers granted therein."

4. Code section 2764 provides:

"The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license."

5. Code section 2811, subdivision (b), provides that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Code section 2761 provides, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. Code section 2762 provides, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or

podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. Code section 4022 provides:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

9. California Code of Regulations, title 16, section 1442, provides:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

10. Code section 125.3 provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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DRUGS

11. "Dilaudid," a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug within the meaning of Code section 4022.

12. "Fentanyl" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug within the meaning of Code section 4022.

13. "Hydrocodone" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)J), and a dangerous drug within the meaning of Code section 4022.

14. "Midazolam" is a dangerous drug within the meaning of Code section 4022.

15. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug within the meaning of Code section 4022.

Background

16. On or about March 14, 2000, the Board received a consumer complaint from Beverly Roling (Roling), Forms Administrator of Kaiser Permanente Hospital, located in San Diego, California. Roling's complaint alleged that during June and September 1999, and in January 2000, "Notices of Disciplinary Actions" had been served on Respondent for repeated controlled substance discrepancies.

17. On or about May 12, 1999, a meeting was held with Respondent and Kaiser Permanente Hospital personnel following a report that on or about May 11, 1999, Respondent had destroyed an original narcotics sign-out after recopying it. An internal audit of facility controlled substances records disclosed that over the course of her employment, Respondent had obtained quantities of medication under the names of other nurses; obtained large dosages of medications, failing to fully account for the disposition of those medications; obtained quantities of medication for surgery patients on dates that those patient's were not listed

on the facility's daily surgery schedule; and, made unintelligible entries in records pertaining to controlled substances. Based on the above, Respondent was suspended for five days.

18. Upon her return to duty at Kaiser Permanente Hospital, Respondent was presented with a Notice of Disciplinary Action for her failure in following facility policy and procedure regarding controlled substances, and failure to follow a set of guidelines regarding controlled substances. Following her return to duty, Respondent continued to violate facility policy and procedures with respect to controlled substance record keeping. On or about February 6, 2000, Respondent resigned from her position with Kaiser Permanente Hospital, in lieu of termination.

FIRST CAUSE FOR DISCIPLINE

(False, Grossly Incorrect, Grossly Inconsistent, or Unintelligible Record Entries)

19. Respondent's registered nurse license is subject to disciplinary action for unprofessional conduct under section 2762, subdivision (e) of the Code, in that while on duty as a registered nurse at Kaiser Permanente Hospital, Respondent committed the following acts involving false, grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to controlled substances:

a. August 2, 1999. Respondent obtained a 2mg. dose of Dilaudid for administration to Patient #1018-06-58. Thereafter, Respondent failed to document and record the administration of 1.5mg. of the medication on the patient's medication administration record, or to otherwise properly account for the disposition of 1.5mg. of the medication.

b. August 16, 1999.

1. Respondent obtained a 4mg. dose of Morphine Sulfate for administration to a patient. Thereafter, Respondent failed to document and record the administration of the medication on the patient's medication administration record, and to otherwise properly account for the disposition of the medication.

2. Respondent obtained a 2mg. dose of Dilaudid for administration to Patient #0877-64-39. Thereafter, Respondent failed to document and record

the administration of .5mg. of the medication on the patient's medication administration record, or to otherwise properly account for the disposition of .5mg. of the medication.

3. Respondent failed to sign off a physician order for the administration of Morphine.

c. August 17, 1999.

1. Respondent obtained a 2mg. dose of Fentanyl for administration to Patient #0886-71-17. Thereafter, Respondent failed to clearly document and record the administration of 1mg. of the medication on the patient's medication administration record, or to otherwise properly account for the disposition of 1mg. of the medication.

2. Respondent obtained a 2mg. dose of Dilaudid for administration to Patient #0447-10-35. Thereafter, Respondent made unintelligible entries on the patient's administration record as to the administration of the medication. Further, Respondent failed to document and record the administration of 1mg. of the medication on the patient's medication administration record, or to otherwise properly account for the disposition of 1mg. of the medication.

2. Respondent failed to sign off a physician's order for the administration of Fentanyl.

d. August 18, 1999.

1. Respondent obtained a dose of Dilaudid for administration to Patient #1328-97-13. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact dosage of medication obtained and administered by Respondent.

2. Respondent obtained a 2mg. dose of Dilaudid for administration to Patient #0450-02-32. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact dosage of medication obtained and administered by Respondent.

e. August 24, 1999. Respondent obtained a 2mg. dose of Dilaudid for administration to Patient #0561-07-68. Thereafter, Respondent failed to document and record

the administration of 1.5mg. of the medication on the patient's medication administration record, or to otherwise properly account for the disposition of 1.5mg. of the medication.

f. September 14, 1999.

1. Respondent failed to initial the final administration of Morphine to a patient on the patient's medication administration record.

2. Respondent failed to sign off a physician's order for the administration of Morphine.

g. September 24, 1999. Respondent failed to sign off a physician's order for the administration of Hydrocodone.

h. September 27, 1999.

1. Respondent obtained 6mgs. of Fentanyl for administration to Patient #0861-77-80. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact dosage of medication obtained and administered by Respondent.

2. Respondent failed to sign off a physician's order for the administration of Fentanyl.

i. September 29, 1999. Respondent incorrectly recorded the medication administration date of September 26, 1999, on Patient #1165-21-80's medication administration record.

j. September 23, 1999. Respondent failed to stamp a patient's medical account billing number in the "imprint" area of the Perioperative Anesthesia Care Orders, Doctors Orders.

k. December 2, 1999. Respondent failed to sign off a physician's order for the administration of Midazolam.

l. January 4, 2000. Respondent obtained 2mgs. of Fentanyl for administration to Patient #0469-63-22. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact

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dosage of medication obtained and administered by Respondent, and failed to otherwise properly account for the disposition of .5mg. of the medication.

m. January 9, 2000. Respondent obtained 4mgs. of Dilaudid for administration to Patient #0192-30-43. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact dosage of medication obtained and administered by Respondent, and failed to otherwise properly account for the disposition of 2mg. of the medication.

n. January 14, 2000. Respondent obtained 2mgs. of Fentanyl for administration to Patient #0561-10-65. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact dosage of medication obtained and administered by Respondent, and failed to otherwise properly account for the disposition of 1cc. of the medication.

o. January 19, 2000.

1. Respondent obtained 2mgs. of Dilaudid for administration to Patient #0523-72-35. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact dosage of medication obtained and administered by Respondent, and failed to otherwise properly account for the disposition of 1cc. of the medication.

2. Respondent obtained 4mgs. of Dilaudid for administration to Patient #0240-83-23. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact dosage of medication obtained and administered by Respondent, and failed to otherwise properly account for the disposition of 1mg. of the medication.

p. January 25, 2000. Respondent obtained 10mgs. of Morphine for administration to Patient #0871-59-18. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact dosage of medication obtained and administered by Respondent, and failed to otherwise properly account for the disposition of 4mg. of the medication.

q. January 27, 2000.

1. Respondent obtained 2mgs. of Dilaudid for administration to Patient #1303-23-07. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact dosage of medication obtained and administered by Respondent, and failed to otherwise properly account for the disposition of 1cc. of the medication.

2. Respondent obtained 2mgs. of Dilaudid for administration to Patient #0228-86-28. Thereafter, Respondent made unintelligible entries on the controlled drug sign-out sheet and the patient's administration record as to the exact dosage of medication obtained and administered by Respondent, and failed to otherwise properly account for the disposition of 1mg. of the medication.

3. Respondent obtained 2mgs. of Fentanyl for administration to Patient #1188-91-67. Thereafter, Respondent failed to document and record the administration of 1mg. of the medication on the patient's medication administration record, or to otherwise properly account for the disposition of 1mg. of the medication.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent's license is subject to discipline for unprofessional conduct under Code section 2761, subdivision (a)(1), for commission of the acts of gross negligence set forth under paragraph 19, above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

21. Respondent's license is subject to discipline under Code section 2761, subdivision (a), for commission of the acts of unprofessional conduct set forth under paragraph 19, above.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 325478, issued to Mary Monica Fedullo;

2. Ordering Mary Monica Fedullo to pay the reasonable costs incurred by the Board in the investigation and enforcement of this case pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 1/18/07

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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